

EXHIBIT A

IN THE COURT OF COMMON PLEAS
DAUPHIN COUNTY, PENNSYLVANIA

No. 2013-CV-702-CV

Civil Action -

☐ Medical Professional Liability Action

TERESA A. THOMPSON, Individually and as
Administratrix of the Estate of Robert W. Thompson,
Deceased

2114 Woodview Drive
Harrisburg, PA 17112

Plaintiff(s) & Address(es)

D & H DISTRIBUTING COMPANY

vs 2523 North Seventh Street
Harrisburg, PA 17110

Defendant(s) & Address(es)

RECEIVED
OFFICE OF
PROTHONOTARY
2013 JAN 23 AM 11:03
DAUPHIN COUNTY
PENNA

PRAECIPE FOR WRIT OF SUMMONS

TO THE PROTHONOTARY OF SAID COURT:

Please issue writ of summons in the above-captioned action.

Writ of Summons shall be issued and forwarded to ☐ Attorney ☒ Sheriff

Loren A. Schrum, Esquire
Reilly, Wolfson, Sheffey, Schrum and Lundberg LLP
1601 Cornwall Road
Lebanon, PA 17042
(717) 273-3733
lschrum@rwssl.com

Signature of Attorney

Supreme Court ID No. 28034

Date: January 18, 2013

Name/Address/Telephone No. of Attorney

WRIT OF SUMMONS

TO THE ABOVE NAMED DEFENDANT(S) *D & H DISTRIBUTING COMPANY*

YOU ARE NOTIFIED THAT THE ABOVE-NAMED PLAINTIFF(S) HAS/HAVE COMMENCED AN ACTION
AGAINST YOU.

Date:

JAN 23 2013

by

Prothonotary

Deputy

☐ Check here if reverse is issued for additional information.

EXHIBIT B

COPY

Loren A. Schrum, ID #28039
Corey M. Lamoureux, ID #311817
Reilly, Wolfson, Sheffey, Schrum
and Lundberg LLP
1601 Cornwall Road
Lebanon, PA 17042
PH: (717) 273-3733
FX: (717) 273-1535
EM: lschrum@rwssl.com
clamoureux@rwssl.com

Counsel for Plaintiff

| | | |
|----------------------------------------|---|---------------------------------|
| TERESA A. THOMPSON, Individually | : | IN THE COURT OF COMMON PLEAS OF |
| and as Administratrix of the Estate of | : | DAUPHIN COUNTY, PENNSYLVANIA |
| Robert W. Thompson, Deceased, | : | |
| Plaintiff | : | |
| | : | |
| | : | |
| Vs. | : | CIVIL ACTION - LAW |
| | : | |
| | : | |
| D & H DISTRIBUTING COMPANY, | : | |
| Defendant | : | No. 2013-CV-702-CV |

NOTICE

YOU HAVE BEEN SUED IN COURT. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this Complaint and Notice are served, by entering a written appearance personally or by attorney and filing in writing with the Court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so the case may proceed without you and a judgment may be entered against you by the Court without further notice for any money claimed in the Complaint or for any other claim or relief requested by the Plaintiff. You may lose money or property or other rights important to you.

YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE A LAWYER, GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW. THIS OFFICE CAN PROVIDE YOU WITH INFORMATION ABOUT HIRING A LAWYER. IF YOU CANNOT AFFORD TO HIRE A LAWYER, THIS OFFICE MAY BE ABLE TO PROVIDE YOU WITH INFORMATION ABOUT AGENCIES THAT MAY OFFER LEGAL SERVICES TO ELIGIBLE PERSONS AT A REDUCED FEE OR NO FEE.

DAUPHIN COUNTY LAWYER REFERRAL SERVICE
213 North Front Street
Harrisburg, PA 17101
(717) 232-7536

**NOTICE CONCERNING MEDIATION OF ACTIONS PENDING
BEFORE THE COURT OF COMMON PLEAS OF DAUPHIN COUNTY**

The Judges of the Court of Common Pleas of Dauphin County believe that mediation of lawsuits is a very important component of dispute resolution. Virtually all lawsuits can benefit in some manner from mediation. The Court has adopted Dauphin County Local Rule 1001 to encourage the use of mediation. This early alert enables litigants to determine the best time during the life of their lawsuit for a mediation session. The intent of this early alert is to help the parties act upon the requirement to consider good faith mediation at the optimal time.

The Dauphin County Bar Association provides mediation services and can be reached at 717-232-7536. Free mediation sessions for pro bono cases referred by MidPenn Legal Services are available through the DCBA.

AVISO

USTED HA SIDO DEMANDADO/A EN CORTE. Si usted desea defenderse de las demandas que se presentan mas adelante en las siguientes paginas, debe tomar accion dentro de los proximos veinte (20) dias despues de la notificacion de esta Demanda y Aviso radicando personalmente o por medio de un abogado una comparecencia escrita y radicando en la Corte por escrito sus defensas de, y objeciones a, las demandas presentadas aqui en contra suya. Se le advierte de que si usted falla de tomar accion como se describe anteriormente, el caso puede proceder sin usted y un fallo por cualquier suma de dinero reclamada en la demanda o cualquier otra reclamacion o remedio solicitado por el demandante puede ser dictado en contra suya por la Corte sin mas aviso adicional. Usted puede perder dinero o propiedad u otros derechos importantes para usted.

USTED DEBE LLEVAR ESTE DOCUMENTO A SU ABOGADO INMEDIATAMENTE. SI USTED NO TIENE UN ABOGADO, LLAME O VAYA A LA SIGUIENTE OFICINA. ESTA OFICINA PUEDE PROVEERLE INFORMACION A CERCA DE COMO CONSEGUIR UN ABOGADO. SI USTED NO PUEDE PAGAR POR LOS SERVICIOS DE UN ABOGADO, ES POSIBLE QUE ESTA OFICINA LE PUEDA PROVEER INFORMACION SOBRE AGENCIAS QUE OFREZCAN SERVICIOS LEGALES SIN CARGO O BAJO COSTO A PERSONAS QUE CUALIFICAN.

DAUPHIN COUNTY LAWYER REFERRAL SERVICE
213 North Front Street
Harrisburg, PA 17101
(717) 232-7536

**AVISO REFERENCIAS A LA MEDIACIÓN DE LAS ACCIONES PENDIENTES
ANTES LA CORTE DE SOPlicas COMUNES DEL CONDADO DE DAUPHIN**

Los jueces de la corte de súplicas comunes del condado de Dauphin creen que la mediación de pleitos es un componente muy importante de la resolución del conflicto. Virtualmente todos los pleitos pueden beneficiar de cierta manera de la mediación. La code ha adoptado la regla local de condado de Dauphin 1001 para animar el use de la mediación. Esta alarma temprana permite a litigantes determinar la mejor época durante la vida de su pleito para una sesión de la mediación. El intento de esta alarma temprana es actuar sobre la mediación de la buena fe en el tiempo óptimo. La asociación de la barra del condado de Dauphin proporciona servicios de la mediación y se puede alcanzar en 717-232-7536. La sesión libre de la mediación para los favorables casos del bono se refinio por MidPenn que los servicios juridicos están disponibles con el DCBA.

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Counsel for Plaintiff

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| TERESA A. THOMPSON, Individually | : | IN THE COURT OF COMMON PLEAS OF |
| and as Administratrix of the Estate of | : | DAUPHIN COUNTY, PENNSYLVANIA |
| Robert W. Thompson, Deceased, | : | |
| Plaintiff | : | |
| | : | |
| | : | |
| Vs. | : | CIVIL ACTION - LAW |
| | : | |
| D & H DISTRIBUTING COMPANY, | : | |
| Defendant | : | No. 2013-CV-702-CV |

COMPLAINT

AND NOW, comes Plaintiff, Teresa A. Thompson, Individually and as Administratrix of the Estate of Robert W. Thompson, Deceased, by and through her counsel, Reilly, Wolfson, Sheffey, Schrum and Lundberg LLP, and files this Complaint, averring as follows:

1. Plaintiff is Teresa A. Thompson ("Plaintiff"), an adult individual who resides at 2114 Woodview Drive, Harrisburg, Dauphin County, Pennsylvania, 17112.

2. Defendant is D & H Distributing Company d/b/a D & H Distributing ("Defendant"), a Pennsylvania corporation organized and existing pursuant to the laws of the

Commonwealth of Pennsylvania, having its principal place of business located at 2525 North Seventh Street, Harrisburg, Dauphin County, Pennsylvania, 17110.

3. Plaintiff is the Administratrix of the Estate of her late husband, Robert W. Thompson ("Thompson").

4. Robert W. Thompson passed away on April 18, 2011. At the time, he was married to Plaintiff.

5. At the time of his death, Thompson was employed by Defendant.

6. Thompson was conditionally offered employment by Defendant on or about July 13, 2010.

7. Thompson began working for Defendant on or about August 2, 2010.

8. At the time Thompson began working for Defendant, his annual salary was \$50,000.00 and he was also eligible for quarterly bonuses. Thompson's conditional offer of employment is attached hereto and marked as Exhibit "A".

9. Defendant offered Thompson its Employee Company Group Benefit Plan ("Plan").

10. Defendant is the administrator of the Plan offered to Thompson.

11. At the time Thompson was hired, Defendant provided him with a document entitled "D & H Distributing Employee Benefits Summary". *See* said document attached hereto and marked as Exhibit "B".

12. In Defendant's Employee Benefits Summary, the Group Life/AD&D Insurance is provided through Unum Life Insurance Company and said insurance is entirely paid by Defendant. *See* Exhibit "B".

13. In addition, when Thompson was hired by Plaintiff, he was provided with a “Summary Plan Description” for Defendant’s group benefit plan. *See* said document attached hereto and marked Exhibit “C”.

14. Neither Exhibit “B” nor “C” state that Thompson must wait one year prior to being eligible for life insurance benefits.

15. Following Thompson’s death, Plaintiff made a claim to Defendant for his life insurance benefits described in Exhibits “A” and “B”. However, Defendant denied such claim.

16. Defendant claims that there is one-year waiting period to be eligible for life insurance benefits despite what is shown on Exhibits “B” and “C”.

17. Defendant’s plan is an employee benefit plan governed in part by the Employee Retirement Income Security Act of 1974 (“ERISA”).

**COUNT I –
PROMISSORY ESTOPPEL/DETRIMENTAL RELIANCE**

18. Paragraphs 1 through 17 are incorporated by reference as if fully set forth herein.

19. When Defendant provided documents to Thompson that it would be providing life insurance to him at no cost, they knew or should have known that Thompson would rely on that assurance and would not obtain life insurance himself.

20. Plaintiff also relied upon the documentation from Defendant and did not obtain life insurance.

21. There is no other remedy except to enforce the Defendant’s promise of life insurance with no waiting period.

WHEREFORE, Plaintiff requests judgment in her favor and against Defendant in such amount as the Court considers just and equitable.

COUNT II – FRAUD

22. Paragraphs 1 through 21 are incorporated by reference as if fully set forth herein.

23. Defendant represented to Thompson and Plaintiff that they were offering life insurance to Thompson through Unum Life Insurance Company without a waiting period.

24. Defendant's assertion to Thompson and Plaintiff that there was no waiting period, and that it was entirely company-paid, is material to this action.

25. Defendant recklessly contends that there was a one-year waiting period for the life insurance despite the documents it provided to Thompson and Plaintiff.

26. Thompson and Plaintiff relied on the documents given to them evidencing that there was no waiting period for life insurance.

27. Plaintiff suffered an injury when her claim for life insurance was denied by Defendant.

WHEREFORE, Plaintiff requests judgment in her favor and against Defendant in such amount as the Court considers just and equitable.

COUNT III – BREACH OF CONTRACT

28. Paragraphs 1 through 27 are incorporated by reference as if fully set forth herein.

29. The failure and refusal of Defendant to compensate Plaintiff for the life insurance policy on behalf of Thompson, pursuant to the benefits offered to him at the time of his employment, is a breach of his employment contract.

30. Solely as a result of the breach of contract, Plaintiff has been damaged in the amount of \$50,000.00.

31. Despite Plaintiff's application for said life insurance benefits and additional demands made, Defendant has failed and refused to pay the life insurance on behalf of Thompson due and owing as set forth in Defendant's benefits summary.

WHEREFORE, Plaintiff requests judgment in her favor and against Defendant in such amount as the Court deems just and equitable.

COUNT IV – ERISA

32. Paragraphs 1 through 31 are incorporated by reference as if fully set forth herein.

33. Thompson's life insurance plan is governed by ERISA.

34. ERISA provides that a civil action may be brought by any plan participant or beneficiary.

35. ERISA allows for recovery of equitable relief.

36. In any ERISA action by a participant or beneficiary, the Court in its discretion may award reasonable attorneys' fees and costs of action to any party.

WHEREFORE, Plaintiff requests judgment in her favor and against Defendant in such amount as the Court considers just and equitable, as well as an award of reasonable attorneys' fees and costs.

COUNT V – NEGLIGENT MISREPRESENTATION

37. Paragraphs 1 through 36 are incorporated by reference as if fully set forth herein.

38. Thompson and Plaintiff relied on the material fact that there was no waiting period for the life insurance plan to begin.

39. Defendant alleges that Thompson's life insurance plan required a one-year waiting period despite documents provided to him.

40. In providing Exhibits "B" and "C" to Thompson and Plaintiff, Defendant should have known its falsity.

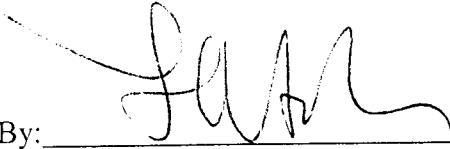
41. Thompson and Plaintiff did not obtain another life insurance plan due to the representation of Defendant that the life insurance plan began immediately and was paid fully by Defendant.

42. Thompson and Plaintiff justifiably relied on Defendant's representation of the life insurance plan.

43. Plaintiff has suffered an injury as a result of Defendant's misrepresentation since her claim for life insurance was denied.

WHEREFORE, Plaintiff requests judgment in her favor and against Defendant in such an amount as the Court deems just and equitable.

REILLY, WOLFSON, SHEFFEY, SCHRUM
AND LUNDBERG LLP

By: 

Loren A. Schrum, ID #28039

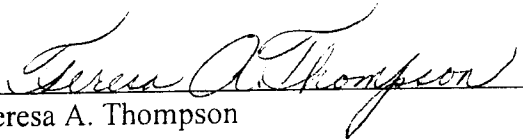
Corey M. Lamoureux, ID #311817

Counsel for Plaintiff

Date: September 9, 2013

VERIFICATION

I verify that the statements made in the foregoing document are true and correct to the best of my knowledge, information and belief. I understand that false statements herein may be subject to the penalties of 18 Pa.C.S.A. § 4904, relating to unsworn falsification to authorities.


Teresa A. Thompson

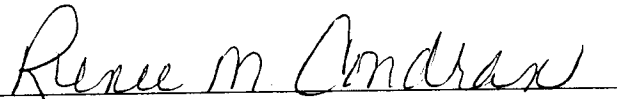
Date: July 30, 2013

CERTIFICATE OF SERVICE

I, Renee M. Condran, a secretary in the law offices of Reilly, Wolfson, Sheffey, Schrum and Lundberg LLP, hereby certify that I served a copy of the foregoing Complaint upon the following by U.S. First-Class Mail, postage prepaid, on September 11, 2013:

Dana Windisch Chilson, Esquire
McNees, Wallace & Nurick LLC
P.O. Box 1166
Harrisburg, PA 17108-1166

Counsel for Defendant, D & H Distributing Company


Renee M. Condran

Date: September 11, 2013

Conditional Offer of Employment

Date 7/13/2010 Name: Robert W. Thompson

Thank you for the interest in the EDI Analyst position within our company. It is with great pleasure that I extend to you an offer of employment with the following program for this position in our IS department.

All offers are conditioned upon satisfactory results on the background check and mandatory drug test.

Compensation

| | |
|-------------------------------------------------|----------------------------------------------------------------|
| Salary \$50,000.00 <input type="checkbox"/> | Monthly (first 0 month guaranteed) <input type="checkbox"/> |
| Weekly 961.54 | Quarterly Bonus \$900.00 (first 2 quarters guaranteed) |
| Hourly <input type="checkbox"/> | Annual Bonus |
| Hourly Rate | Commission |
| Total Potential Annual Compensation \$53,600.00 | |

Partial months for bonus and commission will be pro-rated

Benefits

Contact Corporate HR for description of current benefit programs

Additional Benefits Offered:

This position includes a 90 day test period to make sure we are both satisfied with the employment relationship.

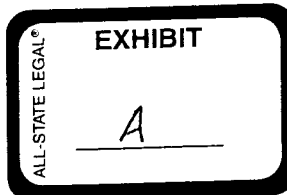
Start date and time: 8/2/2010

Supervisor: Larry Warthin

All employees are at-will employees. Employees may choose to resign at any time, and the employer may terminate an employee at any time, before, during, or after the 90-day test period.

GL CODE _____

| | | | |
|-----------------|------------|----------------|------------|
| Candidate _____ | Date _____ | Employer _____ | Date _____ |
|-----------------|------------|----------------|------------|



D & H DISTRIBUTING EMPLOYEE BENEFITS SUMMARY



Health Insurance

- ✓ Highmark Blue Shield PPO options
- ✓ Full-time employees eligible following 90 days of employment
- ✓ D&H pays 75% of the cost; employee contribution is tax deferred

Dental Insurance

- ✓ Low or high option with United Concordia
- ✓ Full-time employees eligible following 90 days of employment
- ✓ Employees and D&H share the cost; employee contribution is tax deferred

Vision Insurance

- ✓ Available through Vision Benefits of America
- ✓ Full-time employees eligible following 90 days of employment
- ✓ Entirely employee paid/tax deferred

Group Life/AD&D Insurance

- ✓ Through Unum Life Insurance Company
- ✓ Entirely company paid

Employee Assistance Program

- ✓ Cost of three initial counseling sessions covered by D&H

Paid Time Off

- ✓ 6 paid holidays per year
- ✓ Vacation and sick hours accrue regularly
- ✓ 1 paid day to volunteer at the charity of your choice

Company Loan Program

- ✓ Full-time employees eligible following 1 year of employment

401k Plan

- ✓ Eligible to participate the 1st of the month following 90 days of employment
- ✓ 401k contributions are tax deferred; eligible for employer match

Employee Stock Ownership Program (ESOP)

- ✓ Become employee co-owner after 90 days of employment
- ✓ Fully vested in ESOP account after 6 years of employment

Company Paid Education

- ✓ Full-time employees eligible following 90 days of employment

Short Term Disability

- ✓ Full-time employees eligible following 1 year of employment
- ✓ Entirely company paid – benefit % based on years of service

Employee Purchases

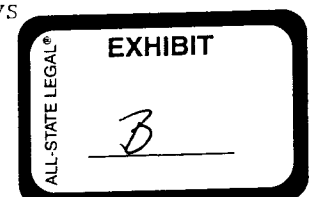
- ✓ All employees eligible following 90 days of employment

Service Award Program

- ✓ All employees eligible beginning with 1st anniversary, then 5th and then continuing in 5 year increments

Reimbursements

- ✓ Annual Physical Co-Pay
- ✓ Gym Membership - \$100 per year
- ✓ Health Screenings Co-Pays
- ✓ Smoking Cessation Aids



Harrisburg 'Perks'

Limited Free tickets for:

- ✓ Harrisburg Senators Baseball
- ✓ Hershey Bears Hockey
- ✓ City Islanders Soccer
- ✓ The National Aquarium in Baltimore

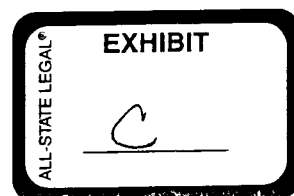
Discounted tickets for:

- ✓ Hershey Park
- ✓ Dutch Wonderland

D&H Distributing Company Group Benefit Plan

Summary Plan Description

Your rights, obligations, and benefits
under your plan



D&H Distributing Company Group Benefit Plan

Table of Contents

| | |
|---------------------------------------------------|----|
| INTRODUCTION..... | 1 |
| OPERATION OF THE PROGRAM | 2 |
| Plan Year | |
| Eligibility | |
| Benefit Options | |
| Spousal Benefits | |
| Explanation of "Pre-Tax Dollars" | |
| Effect on Your Social Security Benefits | |
| Enrollment | |
| CHANGING YOUR ELECTION DURING THE PLAN YEAR | 6 |
| Family Status Changes | |
| Consistency Requirement | |
| Significant Cost or Coverage Change | |
| Special Enrollment Rights | |
| Court Order Requiring Child Support | |
| Medicare or Medicaid Coverage | |
| LEAVE OF ABSENCE AND TERMINATION | 9 |
| If You Take a Leave of Absence | |
| If You Leave | |
| COBRA CONTINUATION COVERAGE..... | 10 |
| Qualifying Beneficiaries and Qualifying Events | |
| Notice of the Qualifying Event and COBRA Election | |
| Cost and Period of Coverage | |
| More Information on COBRA | |
| GENERAL INFORMATION | 12 |
| Insurers Role in Financing the Plan | |
| Maternity and Newborn Length of Stay | |
| Genetic Information | |
| GENERAL CLAIM PROCEDURES | 13 |
| Appealing a Denied Claim | |
| The Future of the Plan | |
| Plan Document | |
| YOUR RIGHTS UNDER ERISA..... | 14 |
| Receive Information About Your Plan and Benefits | |
| Continue Group Health Plan Coverage | |
| Prudent Actions by Plan Fiduciaries | |
| Enforce Your Rights | |
| Assistance with Your Questions | |
| ADMINISTRATIVE INFORMATION FOR ALL PLANS | 17 |
| Plan Name | |
| Plan Type | |
| Employer Identification Number | |

D&H Distributing Company Group Benefit Plan

Plan Number
Plan Dates
Plan Sponsor
Plan Administrator
Named Fiduciary
Agent for Service of Legal Process

D&H Distributing Company Group Benefit Plan

INTRODUCTION

Through the D&H Distributing Company Group Benefit Plan, we are able to offer you a tax-efficient method of paying for your share of health care benefit premiums. By participating in the Plan, you will be paying for your share of the expenses with pre-tax dollars rather than after-tax dollars.

Participation in the **Premium Conversion Plan (PC)** allows you to pay your share of the health premiums on a pre-tax basis. Your payment is made before Federal, State and Social Security taxes are calculated and the cost is automatically deducted from each paycheck.

This Plan is intended to qualify as an Internal Revenue Code section 125 cafeteria benefit plan.

D&H Distributing Company Group Benefit Plan

OPERATION OF THE PROGRAM

Plan Year

This Plan operates on a May 1 to April 30 plan year.

Eligibility

You are eligible to become a member or participant in the Plan if you are a full-time employee and you have completed at least 90 days of continuous employment with the Employer.

Benefits become effective on the first day following completion of these requirements.

Participation in the Plan is completely voluntary. You are not required to accept any of the Benefit Options listed below from our plan.

Benefit Options

The plan provides you with a choice of receiving your full pay or of being covered by the following Employer-sponsored benefit programs and paying your share of the premium cost with pre-tax dollars:

- Medical & Prescription Drug Program
- Dental Program
- Vision Program

The actual carriers and products currently available under each program are listed in the most recent Employee Notice of Currently Included Benefit Programs. The Notice in effect when this Summary Plan Description was printed appears at the end of this booklet. You will be notified of any changes.

Under the health care program(s), you have the option of electing employee-only coverage or one of the family coverages. The types and amounts of benefits available, the requirements for coverage, and other terms and conditions are described in a separate booklet for each of the plans.

Each program provides whether or not your dependents can be covered and defines the term "dependent." If the definition of dependent permits you to elect coverage for someone who is not your "qualifying child" or "qualifying relative" and you elect to cover such a person, the tax law will affect you. At the end of the year, your Form W-2 will include in your taxable income an amount equal to the fair market value of the coverage.

D&H Distributing Company Group Benefit Plan

For example, our Medical Program provides coverage for a college student up to age 25. Employee A elects to cover Child B who is age 24 and attending college. Child B is too old to be A's "qualifying child" under the new tax law. Child B also fails to be a qualifying relative, because the proceeds from the student loan he signed provided more than half of his support for the year. A's Form W-2 for the year will include in his taxable income an amount equal to the premium charge for single person age 24 to be covered by the program.

Under a new Pennsylvania law, an insured health care program may provide coverage for adult children up to age 30. This opportunity may become available as early as January 2010, but its availability will depend upon the particular insured program. To be eligible, the adult child cannot be married or have dependents and must be either a Pennsylvania resident or a college student. The individual cannot be covered under another health care plan. However, as described above, the premium charge for this coverage will be included in your taxable income.

You will be notified of your share of the cost for a particular benefit program prior to the beginning of each plan year.

Spousal Benefits

If you are married, you may elect to cover your spouse under the health care program(s) on a pre-tax basis. Under the Plan, your spouse is the person of the opposite sex to whom you are legally married. If you believe you have established a common-law marriage, your spouse may be recognized as such if you provide to the Plan Administrator a notarized statement signed by both of you. With respect to Pennsylvania residents, a common-law marriage cannot be recognized if the relationship began on or after January 1, 2005.

Explanation of "Pre-Tax Dollars"

Without this Plan, your share of the cost of your benefit options could be paid by you after you receive your pay. This would be payment with **after-tax** dollars, money on which you have paid income tax.

Section 125 of the Internal Revenue Code allows us to set up a plan under which you can contribute your share of the benefit costs with pre-tax dollars. This will save you Federal and State income tax. In addition, most people also save Social Security (FICA) taxes.

D&H Distributing Company Group Benefit Plan

Here are examples of the tax savings from this Plan. The contribution rates are for the purpose of the example and may not apply in your specific case.

Example #1: Employee A works for us and her spouse works elsewhere. They have full family medical coverage costing A \$48.00 per weekly pay. The total family adjusted gross income places them in the 28% marginal Federal income tax bracket. All of A's pay is subject to FICA. A's tax savings would be as follows:

Tax Savings

| | <u>Tax Rate</u> | <u>Weekly</u> | <u>Annually</u> |
|--------------------|------------------------|----------------------|------------------------|
| Federal Income Tax | 28.00% | \$ 13.44 | \$ 698.88 |
| State Income Tax | 3.07% | 1.47 | 76.44 |
| FICA Tax | 7.65% | <u>3.67</u> | <u>190.84</u> |
| Total | | \$ 18.58 | \$ 966.16 |

Due to the tax savings, A's net cost for family medical coverage would be:

| | |
|-------------------|-------------------|
| Total Cost | \$ 48.00 per week |
| Less: Tax Savings | <u>18.58</u> |
| Net Cost | \$ 29.42 per week |

Example #2: Employee B works for us and has single medical coverage costing \$10.00 per pay. B is in the 15% federal tax bracket. B's tax savings would be as follows:

Tax Savings

| | <u>Tax Rate</u> | <u>Weekly</u> | <u>Annually</u> |
|--------------------|------------------------|----------------------|------------------------|
| Federal Income Tax | 15.00% | \$ 1.50 | \$ 78.00 |
| State Income Tax | 3.07% | 0.31 | 16.12 |
| FICA Tax | 7.65% | <u>0.76</u> | <u>39.52</u> |
| Total | | \$ 2.57 | \$ 133.64 |

Due to the tax savings, B's net cost for single medical coverage would be:

| | |
|-------------------|-------------------|
| Total Cost | \$ 10.00 per week |
| Less: Tax Savings | <u>2.57</u> |
| Net Cost | \$ 7.43 per week |

Effect on Your Social Security Benefits

Your Social Security benefits at retirement may be reduced slightly if you participate in the Plan and earn less than the Social Security wage base (\$106,800 in 2010). If you earn more than the Social Security wage base, your benefits are unaffected. For most people, the current value of the tax savings outweighs the potential impact on future Social Security benefits. You should consult your tax advisor regarding your particular situation if you have any questions.

D&H Distributing Company Group Benefit Plan

Enrollment

Approximately one month before becoming eligible to join the Plan, the Plan Administrator will provide you with an election form. On the form, you will be asked to choose your benefit coverage and to agree to the appropriate pay reduction.

The pay reduction will be adjusted automatically if your share of a benefit program cost changes or the insurance company changes its rates.

The form must be returned to the Plan Administrator on or before the date specified. The date specified will not be later than the beginning of the first pay period in which the pay reductions are to begin.

For the first plan year in which you are eligible to participate, if you do not return the election form by the specified date, you will not be covered under any health and welfare programs. You will be able to elect benefit coverage at the beginning of the next plan year.

After you elect and receive coverage by returning the election form by the specified date, you will continue to be covered and your pay will continue to be reduced by the appropriate amount.

You will be asked to make a new election each year. If you make no election, you will continue as a member of the Plan with your current benefit coverage choices.

To request a change in your election during a plan year, submit the election form to the Plan Administrator with your change and reason for change. Your change, if approved, will be effective as of the next pay period that is administratively practicable. Your change can only be approved if you satisfy the requirements described in Changing Your Election During the Plan Year.

If the Plan Administrator determines, before or during any plan year, that the Plan may fail to satisfy for the plan year any nondiscrimination requirement or any limitation on benefits provided to certain employees who own part of our business, who are officers, or who earn above a certain level of compensation imposed by the Code, the Plan Administrator will take any appropriate action, under rules uniformly applied to similarly situated participants, to assure compliance with these requirements. The action may include a change in the elections made by these employees with or without the consent of those employees. You will be notified by the Plan Administrator if it is determined that your elections must be changed.

D&H Distributing Company Group Benefit Plan

CHANGING YOUR ELECTION DURING THE PLAN YEAR

Your Plan elections stay in effect for the entire plan year. However, if you have a change in family status during the year, you may elect to change your elections, including stopping or starting contributions, if your change is consistent with your change in family status. You have 30 days to notify the Plan Administrator of a family status change and the appropriate change in elections using the election form. This may mean that you will need to give notice while on maternity leave or other leave of absence. Your elections under this Plan will be effective as of the first payroll period beginning after the Plan Administrator receives your elections.

Family Status Changes

Family status changes include:

- your marriage, divorce, annulment, or legal separation;
- a change in your dependent child's custody;
- death of your spouse, dependent child, or other eligible dependent;
- birth or adoption (or placement for adoption) of your child;
- any other event that changes the number of your dependents;
- a change in employment status that affects eligibility for plan coverage of you, your spouse, or your dependent, including:
 - a termination or beginning of employment,
 - a strike or lockout,
 - a beginning of or return from an unpaid leave of absence, or
 - a change in worksite;
- an event that causes your dependent to satisfy or to no longer satisfy the eligibility requirements for coverage on account of attainment of an age (e.g., age 19 for health benefits), student status, or any similar situation; and
- a change in the place of residence of you, your spouse, or your dependent. An election change is permissible where the change in residence affects your eligibility for coverage. For example, you may not revoke medical coverage under the Plan merely because you moved, unless as a result of the move you no longer are eligible for such medical coverage.

If you stop or start contributing during the middle of the plan year due to a change in family status, you may only submit eligible expenses that are incurred during the time that you were making contributions to the account.

D&H Distributing Company Group Benefit Plan

If you terminate employment but then resume employment with us within 30 days or within the same plan year, your Plan elections will be automatically reinstated, if there has not been some other family status change.

Consistency Requirement

Your election is required to be consistent with the family status change. If the change in status is your divorce, annulment, or legal separation from your spouse or the death of your spouse, you cannot elect to cancel health insurance coverage for any individual other than your spouse. If the change in status is the death of your dependent or a dependent no longer satisfies the eligibility requirements for coverage, you cannot elect to cancel health insurance coverage for any individual other than that dependent. If the change in status is your marriage or a loss of other coverage for you, your spouse, or your dependent, you can elect to increase your health insurance coverage. If the change in status is a change in eligibility to be covered by a benefit plan due to a change in employment status or residence of you, your spouse, or your dependent, you can elect to change or cancel health insurance coverage.

In addition, if you, your spouse, or your dependent become eligible for coverage under a family member plan through marriage or a change in employment status, your election to cancel or decrease coverage for that individual under this Plan can only be approved if coverage for that individual actually occurs or is increased under the family member plan. A **family member plan** means a cafeteria plan or benefit plan sponsored by the employer of your spouse or your dependent.

If you, your spouse, or your dependent become eligible for COBRA continuation coverage while you are still a participant under this Plan, you may elect to increase payments under this Plan in order to pay for the continuation coverage.

Significant Cost or Coverage Change

Automatic Changes – If the cost of a benefit plan increases (or decreases) during the plan year and you are required to make a corresponding change in your payments, the Plan Administrator will automatically make a prospective increase (or decrease) in your elective contributions.

Elected Changes – If you have a significant cost or coverage change under a benefit program during the plan year, you may make a new election, including stopping or starting contributions or switching to a different plan or program. A **significant cost or coverage change** means:

- your share of the cost of the benefit program is significantly increased by the benefit provider; or
- coverage for all employees under the benefit program is significantly decreased or canceled due to the action of benefit provider.

D&H Distributing Company Group Benefit Plan

You may also make a prospective election change if your spouse, former spouse, or dependent is employed by an employer that provides group benefits and there is a change in those benefits. Your election must correspond with the change made under the other plan. The other employer's plan must either permit election changes like this Plan does or operate on a different plan year.

Effective Date for Your Election – You have 30 days after you receive notice of the significant cost or coverage change to make your new election. Your new election will be effective as of the first payroll period beginning after the Plan Administrator receives your election.

Special Enrollment Rights

Special Mid-Year Group Health Plan Coverage Change – If you or a dependent are not covered by our group health plan, coverage could be elected under the terms of that plan during the plan year. See the description of special enrollment in the group health plan materials. If this happens, you will be permitted to elect to pay your share of the medical premiums under this Plan. Generally, your election under this Plan will not be effective before the first payroll period beginning after the Plan Administrator receives your election. However, if the coverage change is due to the birth, adoption, or placement for adoption of a child, your election under this Plan will be retroactively effective to the date of birth, adoption, or placement for adoption if the Plan Administrator receives the election within 30 days of the event. If you or a dependent have been covered under a Medicaid or CHIP plan and lose your eligibility, you will have 60 days from your termination of coverage to enroll in the group health plan.

Court Order Requiring Child Support

Your benefits can be subject to a court order for child support. The Plan Administrator must honor a court order that complies with the requirements of your health care plan for a "qualified medical child support order." You may obtain, without charge, from the plan administrator for your health care plan a copy of its procedures regarding a qualified medical child support order.

If you are subject to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires health coverage for your child or for a foster child who is your dependent, the Plan Administrator may:

- change your election to provide coverage for the child under this Plan if the order requires coverage for the child; or
- permit you to make an election change to cancel coverage for the child if the order requires your spouse, former spouse, or other individual to provide coverage for the child.

D&H Distributing Company Group Benefit Plan

Medicare or Medicaid Coverage

If you become (or your spouse or your dependent becomes) entitled to Medicare or Medicaid coverage, you may make a prospective election to cancel or reduce coverage for the affected person under your health plan. In addition, if you lose (or your spouse or your dependent loses) eligibility for such coverage, you may make a prospective election to begin or increase coverage for the affected person under your health plan. You will have 60 days from your termination of coverage to make your election.

LEAVE OF ABSENCE AND TERMINATION

If You Take a Leave of Absence

If you take a paid leave of absence, pay reductions will continue to be contributed to this Plan and your coverage will continue.

If you are taking an unpaid leave of absence, you must elect how your share of the premiums will be contributed to your account for the period of leave. You may choose between pre-payment and paying while on leave. You may also elect to discontinue your coverages.

If your unpaid leave qualifies as leave under the Family and Medical Leave Act, you will have the additional choice of making your health care premium payments by having your contributions adjusted upon your return to work.

Military Leave – If you take an unpaid leave of absence due to military service that is protected by the Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA), special rules will apply. If you are employed in Pennsylvania, we will pay your premiums for the first 30 days. If you are absent for 31 days or more, you will need to arrange to pay for your full premium costs. We will not pay any portion of the premium. You may pay to continue your coverage for up to 24 months. If you are not employed in Pennsylvania, your cost will include a small (2%) additional charge for administration.

If You Leave

If you terminate your employment with us, you will no longer be a participant in this Plan. However, coverage may continue under the health care benefit plans you have chosen. You will need to pay for any continuing coverage directly. The booklets for the benefit plan or plans will explain how coverage may be continued.

D&H Distributing Company Group Benefit Plan

COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act (COBRA) may provide you with rights to health care continuation coverage. If you are covered by our group health plan, COBRA may give you the right to stay covered even if something happens, like losing your job, that would otherwise cause you to lose coverage. This continuation coverage under a group health plan is called "COBRA continuation coverage." COBRA continuation coverage lasts only for a limited time, and you have to pay for it.

Qualifying Beneficiaries and Qualifying Events

If you are covered by our group health plan, you, your spouse, and your dependent children may have rights under COBRA if:

- you lose or leave your job, other than by reason of your gross misconduct (if you take an FMLA leave of absence and do not return to active employment, the qualifying event of termination of employment occurs at the end of the leave); or
- you work less hours and our group health plan says this makes you ineligible for coverage.

Your dependent children may include any child who is born to or placed for adoption with you during a period of COBRA continuation coverage, if certain requirements are met.

Your spouse and your dependent children have the right to be qualified beneficiaries for COBRA continuation coverage following your death or divorce or legal separation if they are covered by our group health plan and would lose coverage because of the qualifying event.

COBRA gives your dependent child the right to COBRA continuation coverage for up to 36 months if he or she is covered by our group health plan and would lose coverage because he or she has reached an age or satisfied a condition that causes dependent coverage to end. If you become entitled to Medicare benefits (under Part A, Part B, or both), this would be a qualifying event for your spouse and dependent children. You are not "entitled" to Medicare until you have actually completed the Medicare enrollment and you have been notified your Medicare coverage is in effect.

Notice of the Qualifying Event and COBRA Election

Notice From Us – The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. We are required to notify the Plan Administrator of the qualifying event when you lose or leave your job, your hours are reduced, you die, or you become entitled to Medicare benefits.

Notice From You – In order for the COBRA rights notice and election forms to be provided, the Plan Administrator must be notified if:

- there is a divorce or legal separation;

D&H Distributing Company Group Benefit Plan

- a child ceases to be a dependent; or
- an individual receiving COBRA continuation coverage qualifies for or loses Social Security disability benefits.

You or any qualifying beneficiary are required to give notice within 60 days of the later of:

- the date of the qualifying event; or
- the date the qualified beneficiary would lose coverage on account of the qualifying event.

Notice is to be given in writing. The group health plan may require that a specific form be completed.

COBRA Election – Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect COBRA continuation coverage on behalf of your spouse, and either you or your spouse may elect COBRA continuation coverage on behalf of your children.

If COBRA continuation coverage is desired, it must be elected within 60 days after the later of:

- the date the qualified beneficiary would lose coverage on account of the qualifying event; or
- the date notice is provided to the qualified beneficiary of the right to elect COBRA continuation coverage.

If the Plan Administrator receives notice from you (or someone else who believes he/she is a qualified beneficiary) but determines that no COBRA continuation coverage is required, the Plan Administrator will provide you with a written explanation as to why you are not entitled to COBRA continuation coverage. This explanation will be provided within 14 days of the Plan's receipt of your notice.

Cost and Period of Coverage

Group Health Plan – The group health plan is required to continue the same coverage. All costs of coverage are payable by you after the termination of your employment or by your spouse or child and are made on an after-tax basis. The charge would be equal to the entire cost of coverage, plus a small (2%) additional charge for administration. (If you are getting a longer period of coverage because of disability, you may have to pay more.) COBRA continuation coverage charges can be paid in monthly installments.

If COBRA continuation coverage is elected, coverage generally begins as of the date that coverage would otherwise have been lost. Coverage will then continue for a period of up to 36 months, depending upon the qualifying event.

D&H Distributing Company Group Benefit Plan

Timely Payment – COBRA Coverage will cease if payment is not made timely. For the first payment, the plan must give you (or the qualified beneficiary) at least 45 days after the date of the election. Thereafter, timely payment usually means within 30 days after the first day of that coverage period. The group health plan may permit a later date; read its COBRA coverage notice. If you are receiving severance pay in connection with a termination of employment, you may choose to have your severance pay applied toward your COBRA coverage payments.

More Information on COBRA

The information above covers only basic points. COBRA has a number of special rules. The Plan Administrator is required to give you information about your COBRA rights. You should read that information carefully. If you have any questions about your COBRA rights or would like additional information about COBRA and your group health plan, contact the appropriate plan administrator.

If you want to know more, the Department of Labor has a booklet called "Health Benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA)." You can request this booklet free of charge by calling 1-800-998-7542. The booklet is also available on the Internet at: <http://www.dol.gov/ebsa>.

GENERAL INFORMATION

Insurers Role in Financing the Plan

No health insurance issuer is responsible for either the financing or the administration of this Cafeteria Plan. We are solely responsible for providing the funds pursuant to your election. The responsibility for the financing or administration of your health care benefit plan is as described in the summary plan descriptions provided to you by that plan.

Maternity and Newborn Length of Stay

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

D&H Distributing Company Group Benefit Plan

Genetic Information

Group health plans and health insurance issuers generally may not, under Federal law, obtain or use genetic information when determining premium charges, coverage, benefits, or any other purpose. This rule is not violated if the plan or issuer receives the information inadvertently or for use in monitoring the effects of toxic substances in the workplace. Also, you are free to authorize the disclosure of genetic information when making a FMLA or health-related claim.

GENERAL CLAIM PROCEDURES

If you have a claim against a particular welfare benefit program, you will need to submit it to the administrator for that particular plan under the claim procedure set out in that plan's booklet. If you have a claim against this Plan, you may file a written claim with the Plan Administrator describing the specifics of your claim. If you are requesting a change of election during the plan year, use the election form.

If you experience any difficulty determining your benefits under the group health plan or having a claim processed, you should contact the insurer's help desk. If you cannot obtain the help you need, you may contact Human Resources. The group health plan privacy policy will apply to any health information we are given by you or the insurer. We will not use this health information for employment decisions. The information will be held in a file separate from your regular personnel file and separate from any file maintained for administering sick leave, etc.

Appealing a Denied Claim

If you make a claim and the claim is denied, you will receive a written explanation within 30 days of the Plan Administrator's receipt of your claim. If more time is needed to respond to your claim, the Plan Administrator may use an additional 15 days. You will receive a notice of the extension within the original 30-day period. If the extension is needed because you did not submit necessary information, the notice of extension will describe the required information. You will have 45 days from receipt of the notice to provide the information. The Plan Administrator will respond in about 15 days after receiving this information.

If the Plan Administrator denies your claim, the written explanation of the denial will include the specific reasons for the denial, the Plan provisions on which the denial is based, a description of and reason for any additional material or information needed to process the claim, and the procedure for review.

Within 60 days after receiving the Plan Administrator's notice, you or your duly authorized representative may:

- make a written request to the Plan's Named Fiduciary for a review of your case;
- review upon request and free of charge, all documents, records, and other information relevant to your claim;

D&H Distributing Company Group Benefit Plan

- submit written arguments, comments, documents, records, and other information relevant to your claim.

The Plan's Named Fiduciary will review your case and notify you in writing of the final decision with a full explanation of that decision. Generally, you will receive the decision within 60 days of the Named Fiduciary's receipt of your appeal. If more time is needed to respond to your appeal, the Named Fiduciary may use an additional 60 days. You will receive a notice of the extension within the original 60-day period. In no event will the decision take more than 120 days.

The Future of the Plan

We expect to continue this Plan in the future, but reserve the right to suspend, withdraw, amend, or modify the Plan at any time. If the Plan is changed or terminated, any changes in your coverages, participation, or benefits will be in accordance with applicable law.

Plan Document

This Summary Plan Description highlights the provisions of the D&H Distributing Company Group Benefit Plan and is not intended to modify the Plan Document. In the event of any conflict between this summary and the Plan Document, the Plan Document will govern.

YOUR RIGHTS UNDER ERISA

As a participant in this Plan and in an included health care benefit plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine without charge, at the Plan Administrator's office, all documents governing the plans, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plans, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the plans' annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

D&H Distributing Company Group Benefit Plan

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

There may be a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including us or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse a plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

D&H Distributing Company Group Benefit Plan

Assistance with Your Questions

If you have any questions about these plans, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (800) 347-3756.

D&H Distributing Company Group Benefit Plan

ADMINISTRATIVE INFORMATION FOR ALL PLANS

| | |
|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Plan Name | D&H Distributing Company Group Benefit Plan |
| Plan Type | Welfare Plan |
| Employer Identification Number | 23-0506415 |
| Plan Number | 501 |
| Plan Dates | Plan Effective Date: July 1, 1991 Plan Amended and Restated: May 1, 2010 Plan Year: May 1 to April 30 |
| Plan Sponsor | D & H Distributing Co. 2525 North Seventh Street P.O. Box 5967 Harrisburg, PA 17110-0967 (717) 236-8001 |
| Plan Administrator | The Plan Administrator for general claims under this Plan is available to answer any questions about the Plan. The Plan Administrator is: Benefit Administrator The Plan Administrators and contact information for the included benefit programs are listed in the separate booklet provided by the carrier for the particular plan. |
| Named Fiduciary | Co-Presidents |
| Agent for Service of Legal Process | If, for any reason, you want to seek legal action against the Plan, you can serve legal process on the Plan Administrator for the Plan. |

Effective: May 1, 2010

**D&H Distributing Company Group Benefit Plan
EMPLOYEE NOTICE OF CURRENTLY INCLUDED
BENEFIT PROGRAMS**

The plans now being offered under each of the included benefit programs are:

Medical and Prescription Drug Program

Highmark Blue Shield

Dental Program

United Concordia Companies, Inc.

Vision Program

Vision Benefits of America

This schedule will remain in effect until revoked.

This Notice should be kept with your Summary Plan Description because it describes benefits available under the Plan.

